STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011806	A. BUILDING: _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE OF ANDERSON	1118 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Licensure survey. Survey dates: April 2 and 3, 2014 Facility number: 011806 Provider number: 011806 AIM number: N/A Survey team: Ginger McNamee, RN, TC Karen Lewis, RN Tina Smith-Staats, RN Toni Maley, BSW, (April 2, 2014) Census bed type: Residential: 48 Total: 48 Census payor type: Other: 48 Total: 48 Sample: 7 Primrose of Anderson was found to be in compliance with 410 IAC 16.2 in regard to the State Licensure Survey. Quality Review 04/04/14 by Lisa McColly	R 000		